COUNSELING THE TRANSEXUAL

FIVE CONVERSATIONS WITH PROFESSIONALS IN TRANSEXUAL THERAPY

Erickson Educational Foundation
A NON-PROFIT ORGANIZATION

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CONTENTS

PREFACE

One significant effect of the increasing coverage of transexualism in the popular media is that numbers of transexuals have been enabled to put a name to their trouble, have become aware that professional help is available, and have sought out this help. In consequence, there is a growing need for experienced and enlightened therapists to assist them in making the transition to a new life.

Many members of the helping professions—psychiatrists, psychologists, psychoanalysts, psychiatric social workers, and psychiatric nurses—who are now meeting with transexuals for the first time, are naturally turning toward their colleagues who are experienced in this field so that they may learn from them. These conversations with therapists in the above-mentioned disciplines were undertaken to help serve this purpose.

The therapists with whom we talked were selected on the basis of professional qualifications and extensive experience in counseling transexuals. By all accounts, including those of their patients and of the endocrinologists and surgeons who work in conjunction with them, many of them have been notably successful in this work, although, as will be seen, most of them place strict limits on their possible usefulness to the transexual.

The conversations that follow are to some extent composites. That is to say, although the statements of Dr. B., for example, are principally those of one psychiatrist, the interview may incorporate some of the views of other psychiatrists who generously shared their ideas with us. The initials used to designate the persons interviewed were chosen at random. "EEF" represents the Erickson Educational Foundation interviewer.

A certain amount of repetition and overlapping of ideas will be found among the various conversations. These have been retained for the important purpose of emphasizing areas of agreement shared by many professionals, and which are often crucial to the methods of treatment they employ. It should be noted, too, that the EEF interviewer sometimes adopts the role of devil's advocate, deliberately framing questions which embody misconceptions about transexualism in order to elicit well-defined denials.

In statements which apply to both groups of transexuals, the male-to-female and the female-to-male, the inclusive masculine pronouns are used to avoid the awkwardness of "he and she" or "his and her." Statements particular to one group only are so specified.

Dr. R. is a prominent psychiatrist in private practice. Earlier in his career he was engaged in pioneer sex research and has published important studies in this field. His professional experience with transexuals includes sustained therapeutic relationships with some individuals, and single preoperative interviews with many others, to validate diagnoses of transexualism.

EEF: Many specialists in the field of transexualism are on record as saying that psychotherapy has little or nothing to offer the transexual. Would you agree?

Dr. R.: The only respects in which ongoing therapy may be useful to some transexuals—mind you, I say "some"—is to help them to cope with the people around them or with certain practical problems which may arise; and perhaps in assisting them to be more realistic in the way they envision their future after surgery. But there are many transexuals for whom surgery answers their major needs, and who function quite adequately without therapy.

If one thinks of psychotherapy for the transexual in terms of changing or "curing" them, then you're just barking up the wrong tree. It isn't going to happen. And the great majority of them simply have no motivation to try to affect any change. Even with those who claim to be interested in changing—although in actuality they probably are not—the history of any such attempt through psychotherapy has been almost one hundred percent negative.

EEF: How do you go about diagnosing a transexual?

Dr. R.: I begin by taking a complete sexual history of the person, and a social history: determining how this developed, when it began, and working it through year by year of his life up to the present. And usually I find that the diagnostic indicators appear very clearly, often dating back to his earliest memory.

EEF: Are there any exceptions to this?

Dr. R.: Sometimes you get a later start, say around puberty

or just before. But when this happens you always prick up your ears to determine whether this is in fact transexualism, or whether it is not a case of transvestism. However, if you push very hard to see if you can get earlier indicators, often they're there somewhere along the line.

EEF: Do you find that collateral interviews with the family can be useful, in this or other respects?

Dr. R.: Well, it is helpful on occasion to check with parents or siblings to verify the story, but often they will be completely unaware of the situation. However, other times they can furnish amazing insights into the person, so I certainly consider it worth a try.

EEF: What indicators do you look for in taking a sexual history?

Dr. R.: One of the most important is masturbation. In the transvestite you usually get average or high rates of masturbation. But for the transexual, the rate is usually very low, because they have such a strong antipathy to their organ that they won't even confirm they have it by touching it. Again, if you find the rate is high, you probe to find out how they were able to do this and still maintain the conviction that they belong to the opposite gender. Sometimes male transexuals may vary the technic by lying on a bed and moving up and down while fantasizing that they are female, so that they don't have to confront themselves with their own penis.

And, of course, if you get a male with an extensive history of heterosexual relations, you must question whether he is a transexual. This is another sort of contraindication you will be on the lookout for.

EEF: Do you find an analogous sort of history and behavior in the female transexual?

Dr. R.: Yes, I'd say with female transexuals it's pretty much the same thing, it begins early almost invariably. But there are a couple of important differences. In contradistinction to the male, essentially there are no female transvestites, so with the female it's either transexualism or it isn't. Another complication is that with younger females, transexual or not, you often get low rates of masturbation; so it's a little bit more tricky to decide whether this is because of avoidance of the genitalia or not.

EEF: The generalization has been made that the transexual group on the whole have a relatively low sex drive. Has this been your finding?

Dr. R.: Oh yes, there's no question about this. The sex drive of the male transexual—I'm not so sure about the female—but with the male there's no question that the sex drive usually rates quite low. Here I find Dr. Harry Benjamin's Sexual Orientation Scale, which illustrates six different categories of the transvestism-transexualism syndrome, is a very helpful thing to use. And I very often present this to the individual and ask him to work out his own point on the scale through its various divisions. This can help to clarify his thinking, and hence your thinking, as to whether or not he is a true transexual.

EEF: Would you talk a little more about the differences between transvestism and transexualism? Are these quite distinct categories?

Dr. R.: Yes, they are. For the transexual, dressing is quite incidental. He says, "I'm a female and a female dresses this way, therefore so should I." It isn't an end in itself. For the transvestite it is. You look for fetishes in the transvestite, but you almost never get them in the transexual. Another critical difference is that it's not at all uncommon for the transvestite to engage in heterosexual intercourse while dressed in female attire. And this is, of course, out of the question for the transexual.

EEF: Do you encounter any special characteristic problems in working with transexuals?

Dr. R.: Well, as a group they tend to be very compulsive and determined, so they may push you very hard. But since we are engaged together in making a very important and irrevocable decision, I tend to lean over backwards to go slow, to give it time, so that we're quite certain where we stand. And this can create a lot of tension and heat, because I won't be pushed into making a hasty diagnosis.

Now, for example in the next hour I'll be seeing a man who is one of these very pushing, insistent people who wants me to o.k. the operation right now. But I'm proceeding very deliberately, because in this case I have my doubts. This person lives with a woman and was having sex with her right up to the time he began to take hormones. She's in love with him, and she's very upset that he wants the operation.

So in this instance an important part of the process is to see the two of them together, not only to help me get a clearer diagnosis, but also to try to give her some insights into his motivation, so that she can better accept the situation if we decide to proceed to surgery.

EEF: Have you had any experience with anyone who came to you with a desire for surgery and then changed his mind?

Dr. R.: Yes, I have. Until recently I was working with someone who thought he was a transexual, and I had meetings with his girlfriend too. And he was unusual in going right up to the brink of the operation and then calling it off. He was on hormones and had cosmetic surgery for the Adam's apple, electrolysis—everything but the operation. I felt he couldn't be a true transexual because he was so completely heterosexual and hadn't even had any homosexual experiences. So finally, when the moment was right, I asked him: "What do you want to be, a lesbian?" And that crystallized the contradiction for him, and now he's happily married. But this was a highly unusual case. I only cite it because I want to emphasize that you can't be too careful in forming your diagnosis. For this individual, the operation would have been a tragic mistake.

EEF: In what respects can the therapist be helpful to the transexual in a continuing therapeutic relationship? You mentioned one or two possibilities at the outset of our talk. Will you elaborate?

Dr. R.: Well, I think he can do a lot for the person in helping him to accept the operation, accept the changes in his life this will bring about, get him to think about how he will earn his living in the new gender role, for example.

And often there are problems with the family, with the parents; and I sometimes find myself acting as an intermediary in bringing them all together and helping them to work through their feelings as a family unit. That's a social work job, really, but I find that when it comes from the therapist it can carry more authority, often, than it might coming from a social worker.

EEF: A number of professionals have reported that transexuals frequently seem to be unrealistic about what the future may hold, and tend to regard the operation as a magical panacea. Is that your impression?

Dr. R.: Oh yes, that's very often the case. And that's one more reason why I want to slow them down: so that they don't go into this prematurely, while they still have the expectation that the whole world is going to change for them and with them simply because they've been through a surgical procedure. This reality testing is a very important part of the total preparation, for those people who need it.

EEF: Do you find that there is a great range of degrees of mental health among the transexuals you have seen? And would you, under any circumstances, recommend surgery for someone who might be, say, a borderline psychotic?

Dr. R.: My experience has been that transexuals range from people who are pretty badly psychotic to people who, outside of this one encapsulated problem, function just as well as anybody could imagine. And other people working in this field corroborate this. But even those who are pretty psychotic or highly neurotic, even in areas apart from transexualism, if you establish that they are bona fide transexuals you'll find that after the operation they are no worse off and may be definitely better off, especially with continued counseling.

I'll give you an example. Some time ago a man consulted me—one of the most cantankerous, unattractive, masculine-looking people imaginable. He was even heavily tattooed. And I just didn't feel I could approve surgery for him, because he had so many problems and anyway would have made a most unconvincing-looking woman. Well, he went abroad and did manage to have the operation. Two years later I saw him, and I would say that there was no question of the over-all improvement. He didn't make a very good woman, but then he hadn't been an attractive man either. But the thing that impressed me is how he had quieted down, how much less abrasive a personality he presented.

So, in this case I felt I had probably made a mistake in not recommending surgery, in view of the relative improvement. That experience taught me that some seemingly unlikely candidates for surgery might still do better, on the whole, if they get it.

EEF: In the course of working with transexuals, has experience led you to modify any other ideas that you may have held earlier?

Dr. R.: Well, some years back I believed that one of the prin-

cipal factors accounting for transexualism was abhorrence of homosexuality. That the only way, for example, that a male transexual could have sex with a male without guilt was to have surgery. But in the course of time I've come to feel that this is not the potent and overriding factor I once thought it was. For the true transexual it's a question of total cross-gender identification; and the goal is the whole way of life, with all the social concomitants often foremost, that surgical transformation makes possible.

EEF: When the question of marriage comes up, do you advise your patients in any way as to confiding in the partner about their transexualism?

Dr. R.: Yes, I do. I think that in order to succeed a marriage must be based on total honesty in such important matters. So I always urge them to be completely frank, and in most cases they are. Sometimes premarital counseling is a good idea, an important function of the therapist: to meet with the prospective partner and discuss his or her problems and feelings.

EEF: The gender identity units across the country, and in other countries as well, stress the necessity for the transexual to live for a considerable time, usually two years, in the cross-gender role, as a testing period before surgery. Are you in agreement with this?

Dr. R.: I am, certainly. I think it can't be urged strongly enough, that when they're well along in a course of hormone therapy they start to cross-dress consistently, get a job in the new gender role, and see for themselves what their life will be like, how they'll cope with it. No amount of daydreaming or verbal exploration can substitute for this direct experience, which has a two-fold benefit. First, the transexual gradually acquires a comfort and spontaneity in the new role when he adheres to it all day, every day, over an extended period, that smoothes the rough edges off his manner and makes it unremarkable and convincing. At the same time, he is getting a feedback as other people react to him in his chosen gender role, and these reactions, positive and negative, are part of his education: they reinforce convincing behavior and stimulate him to modify behavior that elicits doubtful or negative responses from others. What I'm saying is that the personal conviction of the transexual as to his true gender identity is not in itself enough to insure that he will do well after surgery. Any conscientious doctor will require that prior to surgery and while receiv-

ing hormone therapy the patient submerge himself in the chosen role for a considerable time—and I would recommend the full two-year term—until he is absolutely at ease in it, personally and socially.

EEF: Do you use any particular method to overcome the resistance of your transexual patients to talking about their problems? One frequently hears that many transexuals have experienced so many rebuffs, and often from professional people, that they are understandably reluctant to open up to a therapist.

Dr. R.: Yes, unfortunately that's true. Often they approach the interview very suspiciously and defensively. The key is to get it across that you are not trying to change them, to make them change their mind, and that you're not uptight about the problem. When they see that I'm really concerned for their welfare and that I have no ax to grind, they calm down very quickly.

One of the problems here is that, unless they specialize in gender identity disorders, at this point in time most therapists aren't likely to see more than two or three transexuals in a lifetime of professional practice. So some of their own preconceptions and resistances never get worked out. And, of course, this immediately comes through to the patient, and it's counterproductive for both of them. Experience and open-mindedness are essential qualifications for success in therapy; and, may I say, this is particularly true in this special case.

Dr. N. is Assistant Director of Social Services at a state hospital which also functions as the teaching hospital of a medical college. In addition to her other duties, she serves as a member of the team of the hospital's gender identity unit. Persons applying to the unit for help are referred to the Clinical Research Department for extensive medical testing, followed by a psychiatric examination. If they are passed for treatment in the program, hormone therapy is initiated, and they are assigned to Dr. N's department for private and group therapy. Parents and even the extended family are also encouraged to meet with the therapist, as is the patient's partner where a serious relationship exists. This involvement in the therapeutic process of people who are close to the patient is, in Dr. N.'s view, an important contributory factor both in preparing him for surgery and in his successful adjustment postoperatively.

EEF: Dr. N., do you employ any special technics in your work with transexuals, as distinguished from those you use with other patients?

Dr. N.: One of the most important things to establish at the outset in any therapeutic relationship is an attitude of acceptance, of openness. This is especially critical to transexuals who, because of the radical nature of their complaint, commonly have met with a goodly amount of rejection, both from the people in their personal lives and, unfortunately, often from the professionals they have consulted. Possibly the fact that, for example, someone who is obviously physiologically female presents herself as a male, with masculine clothes and hair style, and so on, may at first be off-putting. But it is essential that you accept the person for what she believes herself to be.

Now, right at the outset, I should like to correct what I just said, and use the masculine pronoun for this hypothetical person. Because in your discussion of him with your colleagues and even in your own private thoughts about him it is crucial to accept his self-evaluation, even while maintaining a certain critical objectivity. It is possible that at some later point you may discover that he himself has some ambivalence about this self-image, but if you don't accept him from

the beginning as he presents himself, with his chosen gender identity —name, clothing, manner and way of life—then forget it. You've lost him. You must accept him totally from the beginning.

EEF: Is this attitude of total acceptance of what may be pathological in the patient in accord with your professional training?

Dr. N.: I would say that you must, in working with transexuals, revise what you may have been taught in school about what constitutes psychosis and other forms of emotional instability and mental illness. This is not to say that a specific transexual may not be psychotic—some are. But when you hear from a transexual a history of psychiatric hospitalization, suicide attempts, and that kind of thing, you learn to evaluate that differently than you would with other people in your practice. You accept, with the transexual, the almost indescribable degree of torment that they have lived with from as far back as they can remember. Without exception, what they relate to you is an experience of absolute misery from the time of earliest childhood till the present.

And so you have to somehow let it get through to you in your more conventional life that these horrors of loneliness and isolation may have led the transexual to attempt suicide, that his desperation may have caused him to resort to self-mutilation, such as castration. And not get all hung up on the feeling—"they must have been crazy to do this." You have to look at it in the light of the fact that until very recent years they could find no help anywhere in our society, and that they were constantly being told that they were either maladjusted or homosexual or transvestites or something else—which may not have been the case at all.

EEF: How is it possible to overcome the feeling of strangeness, almost of dislocation, that some therapists report in their first dealings with transexuals?

Dr. N.: Well, I found it helpful in the beginning to think of myself as Alice falling down the tunnel; and I think you have to be aware that, in a sense, in our society, you **are** like Alice falling down the tunnel or running after the rabbit. But you will come rightside up eventually if you do accept this new world, accept the transexual just as he represents himself to be. I think that this accounts for the success I've had in engaging transexuals in treatment. I've had too

many years of experience, and I like what I do too much, to be afraid of feelings, and I'm not afraid of theirs. I'm able to accept them as they are; and if the desire to change their body is something foreign to me personally, I am able to understand it for them.

EEF: In the counseling process, does the transference assume any one characteristic definition with the majority of transexuals?

Dr. N.: Yes, I think it does. One has, of course, to stand for various figures and assume various roles, as in all treatment. But I would say that the overriding need is for a maternal figure, and I believe this would be true even with a male therapist. Because it would be most unusual, and even perhaps odd, for a mother confronted with such a radical problem to be totally lacking in ambivalence toward her child. And so this primary role of the nurturing, loving, accepting mother is seldom really fulfilled and often severely damaged in the transexual's life, with a consequent disturbance in the normal process of growth and maturation. This is something that the therapist must supply, as far as he can. And, of course, if you manage to arrange meetings with the parents, there's the chance that you can help them to work through some of the negative feelings, so that they can better fulfill the roles themselves.

EEF.: How do you go about preparing the transexual for the social and emotional changes in his life that will naturally occur post-operatively?

Dr. N.: This is something about which you have to be very dogged and persistent, both because of its inherent importance and because you can so easily be led off the track if you allow the patient to spend an excessive or unproductive amount of time in relating his misery. Now, as I've said, that misery has been intense, and certainly it's essential to allow him to give the fullest expression to his despair, now that he has found a sympathetic listener at last.

But after these feelings have been purged to a great extent—and one has to choose the moment very carefully—then you must gently lead him toward a realistic consideration of some of the problems he may meet in reconstructing his life. You need to remind him that even though his life so far may well have been unendurable, now he has the opportunity to change all that. So you must dispell the

notion that surgery will magically make everything all right, like the wave of a fairy wand. And you carefully dissuade him from living in the past, and help him to make practical preparations for this future.

EEF: And how do you set about doing this?

Dr. N.: You do it in many ways. You examine together, step by step, the medical procedures: what will hormone therapy and surgery entail, what physical changes can be expected, how severe will post-operative discomfort be and how long will it last, and so on. This goes a long way toward alleviating the anxiety that naturally exists. And by being specific in your information about how and when each stage of the process will occur, you can also tone down some of the impatience—the expectation, and often the demand, that everything will be magically and instantly altered.

EEF: And the other phases of preparation?

Dr. N.: Well, you must explore: what does it really mean to be a man?; what does it really mean to be a woman? Because there's no reason to expect that the transexual will be any more free from some of the gender stereotypes than any of the rest of us are. On the contrary, his conception of the gender of choice is often highly idealized or exaggerated—distorted in one way or another. This is only to be expected, considering his life experience.

So we begin with some very elementary misconceptions, which we often get from the transexual himself with very little prodding, and then we examine them together. Is the only "real" man the truck-driver, the soldier? Or can a painter or a dancer be masculine, too? Does femininity mean going to the supermarket drenched in perfume and wearing gauzy organdies and makeup an inch thick—now this sounds like a caricature, but very frequently this is the male transexual's honest conception of appropriate feminine attire, so that's the way she presents herself. Or does being a woman have to do more with an inner quality, a way of feeling: something less obvious, more intangible?

As the transexual, then, begins to gain some cross-gender experience, living in the role of choice, he learns from the therapist, who represents for him the straight world from which he usually has been isolated. He learns by observing the therapist, watching his re-

actions, and of course by asking questions, which I encourage them to do.

EEF: I understand that male and female transexuals participate together in your group sessions. Are there advantages in this arrangement that you would not have in sexually segregated groups?

Dr. N.: Definitely so. When you have both groups together the learning experience is enhanced. Male and female transexuals educate each other from their past experience of living in opposite gender roles.

EEF: Can you give some examples as to how this works?

Dr. N.: Yes. Let's say a male-to-female transexual has had surgery and finds a new job. She's having lunch with the other girls from the office, and someone says, as women will, "I feel out of sorts today, I just got my period. I was going to go to the beach this weekend, but I don't like to swim when I'm menstruating." And then someone turns to the transexual and asks, "Do you prefer to use tampax or kotex?"

Now this was a question that came up in our group when we were role-playing. And the girl who was asked just looked stunned. This was a startling development; she'd never anticipated this situation, nor had the two other male-to-female transexuals who were present. It took a genetic female to invent the situation, based on her experiences in the past. So one thing we try to work out together, both privately and in the group sessions, is how do you bridge that gap of time and experience in your life and inform yourself about it, so that you can speak with some knowledge and authority.

EEF: What other kinds of questions come up?

Dr. N.: Well, of course in therapy the question of family attitudes is of prime concern, but particularly for the transexual, who is planning such a drastic change in his life. We go into this in depth privately, and we extend the discussion in the group. Some of the questions we look into are: what do you want from your family and how much of their approval do you really need?; what is your motivation for surgery, and if you're really motivated are you going to wait until

your family gives their blessings? Because in reality they may never do so.

EEF: Do you tackle such practical questions as vocational plans, for example?

Dr. N.: Yes, I find that this is of particular importance for the transexual. Because male-to-female transexuals, especially, have been too much upset all their life, very few of them have achieved up to their potential. Some may never have worked at all, having been supported by the family or through welfare assistance. Many others settled for menial and boring jobs when often they were capable of much more. So, since most of the people I see fall between the ages of 19 and 25, we emphasize vocational planning, helping them to decide on a course of job training when they're ready for it. And, in many cases, we encourage them to return to school to further their education.

We also go into the methods of changing official identification papers, such as birth certificate, driver's license and social security card; adjusting school and job records; how the female transexual will handle draft registration, and so on. For the trickier problems, you might want to refer them to lawyers who have experience in this area. But if you inform yourself as to the policies and rulings of the various governmental agencies, and learn how these things have been successfully arranged by other transexuals, you can provide a good deal of practical help. When these matters are well managed, not only is the transexual protecting himself from trouble with the law, but a big plus is the reinforced sense of identity he feels when his records and identification papers reflect his chosen gender role.

EEF: Do you provide any guidance about sexual relations?

Dr. N.: These are matters which naturally come up, and we try to provide all the support we can. Other things being equal, this is a simpler matter for the male-to-female transexual, because her anatomy after surgery lends itself to the more usual modes of intercourse. But she may be concerned about children in marriage, and here I can assure her that if she and her husband meet the usual requirements of adoption agencies, it will be possible for her to have a family just like any other woman.

Now the female-to-male transexual, even if he has had a phalloplasty, will have some special concern, in addition to not being able to impregnate a partner. As you know, to date, the constructed penis does not function for sexual intercourse. So you inform him about some of the prosthetic devices that are available. But, above all, I stress the importance of being creative in sexual relations, and that there isn't any one way to have sex. And in his case, if he wonders about having a family, there are two possibilities: artificial insemination for the wife, or adoption.

In discussing these matters, you must be very attuned to the individual's mode and emotional tone, and proceed with extra sensitivity. The transexual may get very depressed about things that would not depress you or me, and he easily can get very discouraged. This may be especially true with regard to sex, which is in a way the crux of the problem, and also the testing ground of his new identity.

EEF: When you become aware that an individual is reaching a dangerous degree of depression, how do you deal with it?

Dr. N.: You do have to be very attuned to this. Sometimes you grant extra appointments. Or you may try to meet with the parents or partner, if the depression stems from these relationships.

With respect to the parents, often the transexual will tell you, "It doesn't really matter what they think," but in most cases this is just bluster. Usually, and quite naturally, it matters very much indeed. So it may not be enough to help him with his feelings about parental rejection, you may need to work with the parents directly. And if they're willing, I've found this can help greatly in stabilizing the patient's emotional state.

So you have to extend yourself at times, and I think this is simply good practice. In that respect, it's no different from working with anyone else: good practice is good practice.

EEF: To return to the question of marriage or a serious relationship: do you give any direction about whether or not to inform the partner about the transexual surgery?

Dr. N.: My practice is never to advise directly. I find role-playing very effective in matters of this sort. I do this with the workers I

supervise and with other patients I treat, when an especially knotty problem comes up and they are pressing for an answer. In this instance, I take the role of the partner and provide reactions and responses; and then we may exchange roles. We may try it both ways, telling about the operation and not telling. Then we might do a critique of his behavior in each role—where it was negative and called forth a negative response, for example.

In dealing with a relationship that was in existence prior to treatment, and that the individual hopes to maintain, other elements come into play. We discuss the partner's reactions so far, and the possibility that the transexual may be so changed, emotionally as well as physically, after surgery, that the relationship might break up. Equally, of course, it might improve. And I make an effort to engage the partner in therapy, to get him to discuss the problems as they arise, and to clarify his or her feelings and overcome resistances where this is possible.

EEF: Is there anything that we haven't gone into that you'd care to add?

Dr. N.: Well, I think I would like to stress that no one should be doing this work who comes to it with a bias. Let's discuss positive bias. If you think that anyone at all who presents himself with sex reassignment as a goal should have that request granted, you may be doing the individual a real disservice. It's happened that when I question someone's reasons, he says, "Well, I just don't feel right." Well he may not be right, but transexualism may not be the reason. It could be some other gender identity problem, or even something else altogether, and he's latched onto this as the most dramatic way of leaving his unhappy life behind. And you don't have to be a brilliant practitioner to know that sometimes the need for self-mutilation may spring from other causes than transexualism.

So it's essential to help the person weigh the alternatives and take a closer look into the future than he probably has done on his own. And if along the way strong doubts arise, either in your mind or his, you are bound to make clear to him what these doubts mean. Because such a radical transformation of an individual's body and his whole way of life should never be undertaken if the indications are not heavily positive.

As far as negative bias goes, it should be axiomatic that anyone who feels that sex reassignment surgery is immoral, unethical, or against God's will, or anything of the sort, should certainly not be working with transexuals. Because there is no possible chance that you can be helpful if your underlying aim from the start is to dissuade him from the course he has chosen. Any growth of self-discovery would be forestalled from the beginning. And, of course, even if your bias remains unspoken, it will be picked up in a minute by someone who is no stranger to disapproval.

I'd also like to say that I believe transexuals should be treated only by people of considerable experience and skill. The beginning therapist has too much to learn even in dealing with more usual problems—for example, in becoming aware that people with marital troubles may actually enjoy and even need constant dissension—and when it comes to people who want to radically transform their anatomy, this may be just too much for an inexperienced therapist to handle. And so I would say that a wide and varied professional experience is essential if the therapist is to be really effective in his work with the transexual.

Mrs. C. is a psychiatric nurse, the head nurse in a gender identity unit at a city hospital which is affiliated with a medical college. Prior to her chance meeting with an indigent preoperative transexual, who presented himself at the intake desk with a request for monetary assistance, Mrs. C. had no clinical and little theoretical knowledge of transexualism. In the course of her attempts to be of help to this individual, Mrs. C. began to look into the pathology and treatment of transexualism. Her concern ultimately resulted in the formation of a gender identity unit which has subsequently diagnosed and treated a number of transexuals. The history of the formation of this unit is included in this report of our interview with Mrs. C., because it demonstrates how a dedicated professional, equipped at the outset with no more than a minimal special knowledge and the strong desire to help one individual, was instrumental in initiating a project which has been of great assistance to many.

EEF: Mrs. C., will you tell us how you came to be interested in treating transexuals?

Mrs. C.: You might say that the unit at our hospital came to be formed almost by accident. I met with a young man at intake one day, and his immediate problem was to get some food and shelter. He had had a falling out with the man he lived with, so he had no money and no place to stay. At first we were concerned with supplying these immediate needs, and I made some contacts for him with the Welfare Department, and so on. Then we talked a while about his general situation and the conversation broadened. He mentioned, a little hesitantly at first, that he was interested in Christine Jorgensen's case. We talked about that for a bit, and finally it emerged that he himself very much wanted to have the same operation.

Quite honestly, prior to meeting this young man I had not dealt with or treated a transexual, and I didn't know of any place that was involved in this work or that could offer him any services. So I consulted a psychiatrist on our staff. I hadn't been aware of it, but it happened that he had had some professional experience in this field when he was working in Casablanca, where many sex reassignment

operations are performed. He wasn't familiar with the practitioners in this country, but he offered to do some investigating for me. After a time, he put me in touch with an endocrinologist who works with transexuals, and this man subsequently began to see the young man on a regular basis for hormone therapy. He also sent us some medical literature which we found to be useful, and at about the same time we became aware of the work of the Erickson Foundation, whose publications and general cooperation were extremely helpful to us at that juncture.

As the young man gained confidence and became more forthcoming in our conversations, I learned a good deal from him about how transexuals experience their problems, and this fleshed out my reading on the subject. At the same time, I realized how much more helpful we could be, for him and others like him, if we were equipped to offer multidisciplinary therapies right here in one place, instead of having to refer him to various doctors at various offices throughout the city. With this idea in mind, I began to approach some of my colleagues to arouse their interest, and finally talked with the hospital administrators.

I encountered many frustrating delays and some strong resistance along the way, but at last the project got moving—slowly at first, but with more momentum as enthusiasm grew. And now we're a fully-staffed unit, with a psychiatrist, an endocrinologist, psychologist consultants, and a psychologist who specializes in testing. I conduct individual and group therapy sessions, together with my cotherapist, who is a Resident at our medical school affiliate, and we're supervised by a staff psychologist. The whole group meets together weekly to evaluate our work and the progress of patients in the program. Now we are both a training and a treatment center. And we continue to receive referrals, through our patients and from other professionals, as they learn about our work. And I can say that all of us are finding this an unusually gratifying and interesting professional experience.

EEF: Does the hospital program carry the patient right through to surgery?

Mrs. C.: Not as yet. We're still feeling our way, since the unit is relatively new. But we have been making an effort to interest the hospital administrators in looking for surgeons who have experience in the field, and I feel confident that they will do so eventually.

EEF: Do you use any special therapeutic technics when you work with transexuals?

Mrs. C.: I'm often asked that question, and the answer is that I work just as I would with anyone else. You gain a patient's confidence by treating him honestly, with interest and respect, and dealing with the problems as they are presented. Just like anyone else who is in difficulties, the transexual needs to know, and to feel, that someone cares enough to spend time trying to help him, and that he is accepted just as he is. And when this really comes across, you're made aware of such overwhelming gratitude—probably because the complaint is so special and people tend to shy away or to react with embarrassment or worse. . . .

EEF: All of the transexuals in your program are pre-operative, then. Do you see both male-to-female and female-to-male transexuals?

Mrs. C.: No, so far there are only male-to-female patients. But we would be very interested in working with both. I'd like to add that the patients in our program all display a high degree of sensitivity and creativity, even though it has been at least partly thwarted as a result of their problems.

EEF: Are there any other common qualities you've observed?

Mrs. C.: Well, yes, I think you can say that they're unusually protective of their partners. Most of the people I see now are living with men they consider to be their husbands. And most of them are economically deprived. The need for relationship is so strong that they tend to be overprotective, to overextend themselves for the partner. For example, if the husband is out of work—and they often are —they will take care of the house, the housework, all the expenses, carry all the responsibilities. And often they can do this only by engaging in prostitution.

EEF: Do you ever make home visits?

Mrs. C.: Yes, we do. Sometimes we're asked to come for a meal or for coffee and cake, and we make it a social occasion. But, of course, these visits serve several purposes. We have an opportunity to estimate at first hand the feeling-tone of a household, and this gives us more to work with in therapy. When you meet family

members and partners, you might take this opening to involve them in the therapeutic process, invite them to come in and talk things over with our staff, where this is indicated. In that way you're provided with a chance to affect the transexual's total situation for the better, accelerate the process. It's as a result of these visits, by the way, that I made my earlier observation about the unusual creativity of the transexuals in our program. The furnishings, the paintings they've made themselves, the way of preparing and presenting food, indicate a highly developed esthetic sense.

EEF: Let's talk a little about your group therapy sessions. What are some of the questions that come up?

Mrs. C.: I'd say the main concern is "How are we going to afford surgery?" Financial questions are a great source of anxiety in this group. And not only with regard to surgery, but electrolysis, too, which, as you know, is a long process and an important one.

EEF: With respect to the more subjective or emotional problems, do you find that the group meetings reinforce the private sessions?

Mrs. C.: Yes, they are generally very supportive of each other. Members who've had more individual work really extend themselves, so that everyone can benefit from their experience. For example, one person who had had about six months of hormone therapy, but was still living in a relationship with a female, expressed his ambivalence quite intensely one day. He didn't really know whether he wanted to go forward or back, and he'd been oscillating for some time. Well the unanimous advice, with which I agreed, was to wait a bit before making a final decision—give yourself a chance to make sure that whatever you decide is really, clearly what you want.

EEF: I understand that, in addition to the therapies offered by the gender identity unit, patients get some help from the hospital's vocational rehabilitation services.

Mrs. C.: Yes, that's right. I consider this to be an extremely valuable aspect of the total process of rehabilitation, because, as I've said, their education and job experience usually is severely limited. The rehab workers administer intelligence and vocational aptitude tests, and then proceed to job counseling. And, where this is indi-

cated, we refer people in our program to state agencies that will assist them to continue their education, or enroll them in job training programs. I can't tell you how rewarding it is to see people moving out into the world who may never before have had any hope of functioning in accepted ways in our society: passing high school equivalency tests, learning new skills, getting oriented in productive jobs. Even a small measure of social success goes quite a long way for people who've enjoyed so little.

EEF: Are there any other remarks you'd like to make?

Mrs. C.: Just this personal statement. That I'm delighted that we persisted, often against odds, in educating ourselves and our colleagues, in overcoming wariness and prudence and ignorance of the subject, so that we finally equipped ourselves to serve our transexual patients. I think I'm not speaking only for myself when I say that none of my professional experiences has been as gratifying as this one—as being able to be of help to people whose problems are so radical, so special. The substantial evidence of improvement among the patients, through the administration of appropriate therapies, has been striking, and greatly rewarding. We have in preparation now studies of various aspects of our program, and we hope that when these are published they will make some contribution to the very good work that's being done now in this field.

Dr. T. is a psychoanalytic psychotherapist in private practice, whose special area of interest is problems of identity. She has treated several transexuals. In the course of this record of our interview, it will become apparent that she is in some disagreement with the other professionals whose views are reported here, with respect to the motivations and the manifestations of transexualism in the people with whom she has worked. This may perhaps be attributable to her psychoanalytic orientation. In some instances, her opinions coincide with those that our other interviewees tell us they once held but have now discarded. For this reason, her elaboration of these views will, we believe, be instructive.

EEF: Dr. T., are there particular technics which you find especially helpful in your work with transexuals?

Dr. T.: In working with transexuals, I think you have to keep in mind that their needs and wishes are often quite different from those of the therapist. Primarily, they frequently come not because they want therapy but for validation of their goals. So I feel it is important to establish that I am not there to urge or ratify a negative or positive decision for surgery, but to help them explore and clarify their own feelings so that they can make the best decision themselves. And for myself, as a therapist, I try to stay open-minded, to see them not as transexuals but as people, people with serious problems. Apart from this, I work with them much as I would with any other patients.

EEF: I understand that you are especially interested in problems of identity.

Dr. T.: Yes, and my interest in transexuals stems from their very weak or confused sense of self. What you get is an obsessive concentration on changing the genitalia, as though the sexual organ provides the totality of gender. An important function of the therapist, then, is to get across to them that they are persons and that they will remain a person whether or not they have the operation. You try to help them to develop this sense of person-hood, and divert them

not from going on to surgery but from this obsessive preoccupation with the sexual organ.

EEF: Would you say, then, that the motive in coming to see the therapist is roughly the same in all your transexual patients?

Dr. T.: I think that they are all looking to fulfill emotional needs that, because of guilt, they feel can't be fulfilled unless they have surgery. I'm aware that many specialists in this field disagree with me, but, based on the limited number of transexuals I've seen, it's my feeling that they are basically homosexual. And the difference between them and acknowledged homosexuals is that they have such enormous guilt that they are willing to undergo the trauma of surgery in order to live peaceably with themselves. The men I have worked with who want to be women don't really like women and identify with them. What they want is to get what women get—which is men. I'm aware that this may be a minority opinion, and perhaps I would modify it after more extensive experience. But this is my observation based on the people I have seen.

EEF: Have you worked exclusively with male-to-female transexuals?

Dr. T.: I have seen only one female-to-male transexual professionally. And by the way, here my impression is in accord with that of many specialists in transexualism—that the female-to-male seems much more stable, much sounder and more realistic, better able to cope with the world, than the male-to-female transexuals I've seen. But again I must emphasize that there was only this one therapeutic relationship with a female-to-male transexual. Also, she was more fully accepted by her family than many transexuals, and this may have been a factor.

EEF: Are you saying that most of your male-to-female transexual patients are pretty deeply disturbed?

Dr. T.: There is some variation, but, yes, I have found that many of them display borderline or more serious symptoms.

EEF: Do you discern any common pattern in development of gender identity in early childhood?

Dr. T.: You find a great deal of confusion when you try to trace it back. Usually in the first session you are told that all their life they wanted to be a girl, felt they were girls, but later some contradictory features emerge. You have the impression that for a very long time there was a sense of not knowing who they were, without this being clearly defined as to one or the other gender. The earliest feeling is that they don't fit in, and not necessarily that they were really girls and not boys.

EEF: Apart from the obsessiveness you described, have you noticed any other common characteristics in the transexuals you have treated?

Dr. T.: I would say that there is almost invariably the magical wish, the illusion, that all it will take is this one surgical procedure and their life will be instantly transformed. There is little desire to undertake the work of finding out who they are and what the totality of life can hold for them and how to go about getting it.

EEF: How do you distinguish your transvestite from your transexual patients?

Dr. T.: I think the difference is most specific. The transvestite —and this is true of homosexuals also, especially those who enjoy sex—transvestites never want to give up their organ. They often get the release they need simply by dressing up. The transexual will usually tell you that he gets no pleasure from his organ and finds it ugly. Now, once more I'm aware that this is a minority opinion, but based solely on my own work, I'd say that the male-to-female transexual also finds the vagina ugly. And so what I see is a tremendous confusion, a lack of differentiation, which may be interfering with the way they view themselves and others. Still, their fantasy is to be a girl, and the operation is never very far from their mind.

EEF.: Earlier we touched briefly on therapeutic technics. Is there anything you wish to add?

Dr. T.: Basically I use the same technics with all my patients: interpretation, confrontation, questioning. In this instance, I try to help them see themselves in as undistorted a manner as possible: that's my essential aim. But often I find that as non-threatening as I try to be, as clearly as I assure them that I have no stake in whether

or not they have the operation, I rarely succeed in getting this firmly across. They come in with the feeling that I have a preexisting judgment and certain values and that I will try to dissuade them from going ahead to surgery. And if this conviction continues to be strong and persistent, eventually they will drop out of therapy prematurely. I think this is the great obstacle.

When a patient does accept my disinterestedness, he stays with it longer, and I'm able to be of some help. But, generally speaking, I think the sense of self is so under-developed, and the desire for surgery so obsessive, that what they persist in wanting from the therapist is no more than to have this other human being validate what they feel. So, regrettably, although I may help to mitigate some discomforts, I've never been able to be of as much help as I would like to be.

EEF: Is it possible that, as other doctors have recognized for themselves, their desire for such radical surgery does in fact modify your attitude toward the transexual? That you find it hard to accept that, for example, an attractive biological male should be so committed to this drastic and fundamental transformation?

Dr. T.: No, not at all. I simply feel that these are people and that I'm interested, I want to work with them. No, I think that the difficulty is theirs, that they are very threatened at the prospect of looking at themselves as people, beyond the genital obsession.

EEF: In the medical literature, it's commonly observed that, generally speaking, transexuals, particularly male-to-female transexuals, manifest a relatively low sex drive. Would your findings, in taking sexual histories, agree?

Dr. T.: Yes, I would say so. For those I have seen, the sex act is really a means of accommodating the partner and a way of establishing some kind of permanency in the relationship. I don't get a feeling of sexual passion, but more of emotional need.

EEF: Apparently in your practice you have seen preoperative transexuals exclusively. Have you ever had the opportunity to meet any postoperative transexuals who seemed to you to be at ease and convincing in the elective gender?

Dr. T: Yes, at professional meetings I've met two or three people I would have totally accepted in the chosen gender. But more commonly, especially with male-to-female transexuals, there is a kind of over-emphasis, an exaggeration of physical presentation and manner, of gesture, that is studied and unconvincing. It's as if the gesture in itself is the important thing; it seems manufactured, rather than a natural expression of inner feeling, of integrated behavior. In other words, I find them very fragmented, and perhaps this is what they feel about themselves.

Dr. B. is a psychiatrist in private practice. He is held in high regard by the surgeons, endocrinologists and psychiatrists specializing in transexual therapies with whom we have consulted in the preparation of this and other EEF publications. His professional contact with transexuals consists largely in the single in depth psychiatric evaluation that precedes surgery. Based on his considerable experience in this field, it is Dr. B.'s conviction that psychiatry does not afford any significant help to the transexual in the absence of surgery as the effective element in therapy. Postoperatively, he says, the psychiarist may be useful in assisting the individual with problems of reorientation, where these exist, and Dr. B. has worked with a few such patients.

EEF: One frequently hears that transexuals are often suspicious and defensive in talking with psychiatrists, sometimes because of a previous bad experience. What approach would you say is best designed to elicit an honest and full presentation of pertinent information?

Dr. B.: What I would say to the doctor who has not had experience in talking with transexuals is that he must at the outset establish an atmosphere of sympathy and understanding. Too often I am told by patients that they have the impression that doctors regard them as odd fish, that they seem to squirm inwardly at the transexual's desire for such radical surgery. If your attitude is so transparently negative, or even ambivalent, you can't hope to accomplish anything at all. You're useless to him from the start.

So what you want to convey—and, of course, you must feel it to convey it, you must work your feelings through—is that you understand the intensity of the motivation for surgery; and that you realize that the urge to be "changed" is not, for the transexual, a wish to be changed from one thing to another, but the desire to become what he has always felt himself to be. His goal is the creation of a body that conforms to his body image—his feelings about himself since his earliest memory.

EEF: In your experience, at what point in his life does the individual first recognize that he is a transexual?

Dr. B.: The time is difficult to pinpoint, because his first awareness of his inner makeup is rarely so specifically defined. You get statements like: "I always felt a little different, but I didn't know what the difference was." Or: "I knew I didn't like to do things other boys my age liked to do." So the clear awareness of the male-to-female transexual, for example, that he is a woman in a man's body often does not surface until adolescence or later. Sometimes the transexual's insight may begin as a confused feeling that he or she is homophile, yet is repelled by the homosexual character of the partnership.

EEF: Would you say that the abundance of information available today concerning sex and gender problems is helpful to the transexual in defining his conflicts?

Dr. B.: Yes, I think this is so. I've been told many times that reading Christine Jorgensen's book, or hearing about her, provided a key. Patients say that this experience opened up a new vista, gave them an orientation that seemed at last to fit what they have always felt about themselves but never fully understood.

EEF: Postoperatively, do most transexuals report that surgery has fulfilled their expectations, and are these positive effects manifest to you as a trained observer?

Dr. B.: Of those patients I have interviewed, and with very rare exceptions, their universal feeling postoperatively is that a great burden has been lifted, and that now they can happily embark on a new life. This relief is clearly observable. And I find that for the most part they are able to cope fairly successfully with any practical problems that may arise in postoperative life.

EEF: In arriving at a preoperative evaluation, what key indications favorable to surgery do you look for?

Dr. B.: I evaluate the inner or emotional state, as well as the social adjustment to cross-gender life during the preoperative period of trial living in the chosen role. These are paramount. And if these indications are strongly positive, I may even decide that they outweigh the possibility that the individual's physical appearance in the elective

role may not be altogether satisfying. That handicap may not prevent him from enjoying a greater measure of tranquility than he did prior to surgery, if his social and emotional adjustment is good. But, of course, when the cosmetic indicators are below par, you make your recommendations with care.

EEF: Is an improved or more active sex life a primary goal for the transexual who seeks surgery?

Dr. B.: The importance of the sexual aspect postoperatively varies considerably among individuals. Some older people will tell you that they don't envision an active sex life at all. Their satisfaction consists entirely in the new-found agreement of their anatomy with their inner self-image. The daydream about the white knight who'll sweep you off your feet into a happy-ever-after, which you find in some of the more unrealistic, younger transexuals, is usually, fortunately, absent here. And, parenthetically, some few male-to-female transexuals I've seen may even continue to dress in the former gender role, perhaps for business or other practical purposes. But they are sufficiently relieved to know that under their clothes their body now conforms to the inner picture of themselves.

At the other end of the spectrum, there are transexuals who do consider the sexual aspect of postoperative life to be primary. Some have partners prior to surgery with whom they plan to marry. And they anticipate an active sexual experience through the newly created vagina. Often their plans include the adoption of a child. So it's through this feeling that they can function fully, sexually, as a woman that they lay their broad plans for the future.

EEF: You mentioned earlier that a few transexuals continue to dress in the former gender role even after surgery. A minority psychiatric opinion holds that simply cross-dressing, without surgery, may provide sufficient relief for some transexuals. Do you agree?

Dr. B.: Categorically, no. For the true transexual his primary and secondary sex characteristics are abhorrent and his aim is to have these altered to the fullest possible extent. For example, the male-to-female transexual is not satisfied with castration, where this has occurred, but insists on the creation of a vagina, which becomes the central focus of the desired transformation. Castration does not intrinsically alter the self-image; rather, it is the created vagina that is the

confirming badge and seal of womanhood, proof positive in their mind that they now have fulfilled the inner self-image. So with this common example in mind, when we see that not even the removal of the offending organ affords any relief, it's clear that we're simply romancing if we imagine that cross-dressing alone is sufficiently therapeutic for the bona fide transexual.

EEF: Relatively few female-to-male transexuals have undergone a phalloplasty, but presumably their feelings about their genitalia are not dissimilar to those of the male-to-female transexuals about theirs. How do they adjust then, to the absence of their "confirming badge"?

Dr. B.: I haven't had the opportunity to see many female-to-male transexuals, probably because of the relative instances of the two types. And while it is true that relatively few female-to-male transexuals insist upon the creation of an artificial phallus, this would not to my mind indicate that a created organ has any less importance in this case. It simply reflects an acceptance of the fact that, as her doctor will inform her, the technics for this surgical procedure are at present far from being perfected, and that the results would leave a great deal to be desired. But, as with the male-to-female transexual, so with the female-to-male counterpart: I know of no female-to-male transexual who clearly understands her psychosexual makeup who would be content to simply acknowledge it and continue as she is. Mastectomy and hysterectomy are always desired, and in the majority of cases the alteration of appearance and of internal processes that these achieve provides the desired relief. But presumably when the results of phalloplasty are more satisfactory than they are now, the desire for the created organ probably being as strong in the female-to-male transexual as in the male-to-female transexual, then I would anticipate that the request for this procedure would be accordingly universal.

EEF: In conclusion, is there any point we haven't covered that you would like to make now?

Dr. B.: I'd simply like to return to the first point I made, to give it its fullest value. And that is that the doctor, whatever his area of specialization, can make his greatest therapeutic contribution by communicating to the transexual a sense of understanding, of regarding him as a member of the human race equal to any other. Too often I have heard of the humiliating and debasing guffaws and wisecracks

that patient after patient has had to endure before finally getting in touch with people who really understand.

CONCLUDING REMARKS

In reviewing these interviews with specialists experienced in counseling transexuals, we notice differences on some points of lesser importance. What is more striking is the significant degree of unanimity on the principal aspects of diagnosis and treatment, among those professionals convinced of the effectiveness of sex reassignment surgery.

One of the most notable points of agreement, and one particularly emphasized by the psychiatrists, concerns the limited usefulness of counseling in the total process of transexual therapy. Stated or implied in all the interviews but one is the premise that the primary and indispensable mode of treatment for transexualism is sex reassignment surgery and the hormone therapy that precedes and follows it. Drs. R. and B. are so far assured of the effectiveness of these medical procedures that they are at pains to say that they may be justified even in some cases where cosmetic indications are not altogether positive or psychic health is less than optimum. Relative over-all improvement in many such cases, they say, may warrant the recommendation of surgery even for these individuals.

In what respects, then, may the counselor be of assistance to the transexual? Drs. R. and B., whose work is mainly diagnostic, agree with Mrs. C. and Dr. N., who have extended therapeutic relationships with transexuals enrolled in gender identity clinics, in defining the role of the counselor as chiefly a supportive one: he prepares the transexual for surgery and assists him in his adjustments to postoperative life. Specific points mentioned are: fostering self-acceptance and realistic expectations; helping to work out troubled relationships with family and partners; advising on vocational plans, changes in identity papers, and related practical matters.

These counselors also state that their services, though useful to those who need them, are by no means universally required. In Dr. R.'s words: "My experience has been that transexuals range from people who are pretty badly psychotic to people who, outside of this one encapsulated problem, function just as well as anybody could imagine."

Group therapy is discussed here, and it is a method the effectiveness of which we should be learning more about in the future, par-

ticularly from those therapists associated with gender identity units, who have the greatest opportunities to explore its usefulness. Mrs. C. and Dr. N. have found it to be a productive technic, and Dr. N. specifically recommends the mixed group of male-to-female and female-to-male transexuals, where each group is able to inform the other about the various social aspects of life in their preoperative gender roles.

A common observation in these interviews, and one that should be helpful to counselors who are new to this field, is that transexuals, although they commonly recognize quite early in life that "something is wrong," usually are not able to define this "something" in terms that clearly indicate transexualism until somewhat later in life. The classic presenting complaint of the adult transexual that "I am a man/woman in a woman/man's body" is a relatively late formulation. Dr. N. warns that, at least in some instances, the leap from "something is wrong" to "I am a transexual" can be made arbitrarily. In every case, all the therapists agree, a diagnosis of transexualism, for which the prescribed treatment is radical and irreversible, should be made only after the most painstaking evaluation. The data for a final judgment may be largely drawn from the patient's adjustments to the preoperative period of up to two years spent in the cross-gender role.

A frequently dissenting voice here is that of the psychoanalytically-oriented Dr. T., who disagrees with her colleagues in several respects. She is aware of this, and often qualifies her statements by reminding the interviewer that her experience in this field is fairly limited. A point of which we should take special note, since it must necessarily influence the essential direction of her therapeutic practice, is her hypothesis that the transexual is basically a homosexual who cannot accept his homosexuality and chooses surgery as the way out of his dilemma. This is certainly, as she states, "a minority opinion"; and it is noteworthy that Dr. R. tells us that this is a view he originally shared, but finally rejected in the course of his extensive experience in this field.

This brings us to another matter which was stressed by everyone we interviewed: that the therapist who is most successful in his work with transexuals is ideally one who can bring to bear the knowledge and sensitivity acquired from extensive and various professional experience. In describing the initial disoriented reactions of some therapists to their early encounters with the relatively rare and radical difficul-

ties of the transexual, Dr. N. uses a suggestive metaphor, comparing the therapist with Alice through the looking-glass. She advises that unless the therapist accepts without reservation the unfamiliar logic of this strange territory, his usefulness to the transexual must be minimal at best.

That he should cultivate an unbiased acceptance of the people who come to him for help, an innocence of preconception, is certainly axiomatic to the practice of every effective therapist. All of the people interviewed here felt called upon to especially emphasize this point with regard to their transexual patients, and with particular eloquence and intensity. These statements testify to the fact that it is possible for even a well-established professional equilibrium to be temporarily disturbed by the extreme and unusual nature of the transexual's complaint, and to the necessity for this equilibrium to be restored and maintained if productive work is to be accomplished. Dr. B.'s appeal that the transexual be regarded as "a member of the human race equal to any other" is responsive to the reports of numbers of transexuals concerning the indifferent or brutal rejections they experienced not only from family and friends, but also from professional people to whom they turned for help.

Transexuals are, indeed, members of the human race; and their rehabilitation by means of sex reassignment is a significant mode of rehabilitative medicine.